GROUP INSURANCE COMMISSION

Charles F. Hurley Building
19 Staniford Street
Boston, MA 02114

MINUTES OF THE MEETING

NUMBER: Six Hundred Thirty-Eight
DATE: February 6, 2018
TIME: 3:00 P.M.
PLACE: 1 Ashburton Place,
Boston, MA 02108

Members Present:

VALERIE SULLIVAN (Public Member), Chair

GARY ANDERSON, (Commissioner of Insurance)

TAMARA P. DAVIS (Public Member)

EDWARD T. CHOATE (Public Member)

CHRISTINE HAYES CLINARD, ESQ. (Public Member)

JOSEPH GENTILE (AFL-CIO, Public Safety Member)

BOBBI KAPLAN (NAGE)

JANE EDMONDS (Retiree Member)

MICHAEL HEFFERNAN (Secretary of Administration and Finance)

MARGARET THOMPSON (Local 5000, SEIU, NAGE)

TIMOTHY D. SULLIVAN, Ed. D. (Massachusetts Teachers Association)

EILEEN P. MCANNENY (Public Member)

KEVIN DRAKE (Council 93, AFSCME, AFL-CIO)

Vacant Seats:

Health Care Economist

MMA

Members Absent:

THERON R. BRADLEY (Public Member)

MELVIN A. KLECKNER (Massachusetts Municipal Association)

Chair Sullivan opened by stating that there was a short agenda for this particular meeting. Usual business, such as review of January meeting minutes, would be deferred until February 22nd. The Chair then introduced the Executive Director.

The Executive Director explained that there were two agenda items to cover, the first being medical benefits and the second being updated materials. Materials were previously distributed at the last Commission meeting, and subsequently the Commissioners received updated materials via e-mail.

The Executive Director explained the unusual configuration of the room, pointing out that the presentation was behind the GIC staff in order to provide a better view for the Commissioners and audience. She also noted that after the presentation concluded, the Commission would also review the budget for open enrollment.

The Executive Director briefly recapped where the Commission left off at the last meeting. She explained that what the GIC was specifically directed to continue to do was to conserve several strategic goals of the procurement process. Specifically, the GIC continued to look for a set of solutions that involved carving out and consolidating pharmacy management. The Executive Director also reminded the Commission of its other goals, that being to have the health plans carve in behavioral health and to convert universally to a self-insured platform. She also restated that the Commission had had two options to choose from at the previous Commission meeting regarding Option A versus Option B, and had elected Option B. Among the commitments that the Commission made with this decision was that the GIC would continue as best it could with its goal to meet the mandate that the agency had been given to keep premium costs as low as possible, and to hold down out-of-pocket expenses, particularly from a member point of view. What the GIC was trying to accomplish was to combat what members said they had been experiencing, which was health plan costs rising faster than wages. In aggregate, the agency was trying to keep costs to a total of less than a 2% increase.

The Executive Director also took a minute to acknowledge and thank Representative James O'Day from Worcester, who was in attendance and who also attended the public hearing in Worcester. The Executive Director also asked if there were any housekeeping issues that needed attention; there were none.

The Executive Director presented the different components of the potential benefit and commercial plan design changes that the GIC modeled, and what the financial cost or savings related to each of those could be. Regarding the portfolio, the Executive Director highlighted places where the recommendations varied from the past year.

The Executive Director said that the cost of the recommended design changes for commercial plans, in aggregate, was $7.9 or almost $8 million. The bulk of that cost was related to lowering the deductibles on some regional and limited network plans. Currently, all of plans have deductibles of $500 (individual) and $1,000 (family). She noted that proposing to reduce deductibles is something that has never been done before. We were proposing to take them down to $400 and $800 for that set of products.

She outlined other changes that the staff recommended to make to the portfolio. These include having more consistent out-of-pocket maximums. Previously, not all of the health plans were able to do this consistently. This change would result in a very small net savings. She noted that most things being proposed resulted in a relatively small net savings.

She said that the staff wants to align Fallon's deductible with the other plans so that it has medical deductibles of $500 and $1,000, and a pharmacy deductible of $100 and $200. Fallon was not able to implement separate deductibles last year. Additionally, the Tufts Spirit hospital inpatient copay will be rationalized with the rest of portfolio. That change has no actual measurable cost.

She recommended that the specialist copay be reduced reflecting feedback from our members. Although there continues to be an important place for tiered products and tiered copays, benchmarking has suggested that while in general, the GIC's portfolio of products is relatively rich by market standards, the third tier specialty copay--which was currently $90--is too high. The recommendation is to have the third tier specialist co-pay be reduced to $75. This had a cost of almost $2 million.

Additionally, we want the telehealth copay to be consistent with the lowest PCP copay structure. She further recommended making it's the hearing aids benefit consistent across the plans for people who are under the age of 21. That is also a minor adjustment. For the emergency ambulance coverage, we proposed that there be no charge after the deductible for an emergency ambulance, which also has a relatively negligible cost. Lastly, we recommended removing prior authorization for hospice care.

The Executive Director then spoke about the overall procurement and its financial implications. The Commission had made a decision to maintain the overall architecture of the procurement, which included carving out pharmacy. That will yield potential averted expenses of $500 million over three years. Also, the ASO platform saves considerable money in fees. She described how we looked at everything in the aggregate. She clarified that when we say the average weighted enrollment increase for premiums will be less than 2% it does not mean that individual products might not have an increase larger than 2%. .

She noted that, during a procurement year, the process we follow is to (i) first decide on who the vendors should be, (ii) then agree on the benefit design and (iii) lastly determine premiums (rates) on specific products. In aggregate, the recommended changes with the procurement savings result in premium increases less than 2% or, more specifically, the average weighted enrollment increase in premiums would be less than 2%. For particular products in the portfolio, some will be more, some will be less. Inevitably, that always happens.

Commissioner Davis sought confirmation that, if based on the new structure of plans, the costs involved would be $7.9 million. The Executive Director said that was correct.

The Executive Director said that we committed to having the increase, in aggregate, be less than 2%. That number hasn't been handed to us, that particular number is entirely self-directed. We know that in the Massachusetts market, in general, that in the state has set a target for cost increases in the range of 3.1%. She said she thought we should do better than that.

She noted that the GIC has been hearing that folks are very unhappy because their health care costs are going up faster than their wages. We can't solve that for everyone, but we can try to prevent that from happening. She said that the adjustments to the design of the portfolio we proposed are in line with the benchmarking done last year and also helped to address what we heard from our members on the listening tours and public hearings. We want to make good on that overall goal of holding the aggregate costs down to less than 2%.

Commissioner Davis noted that during the procurement process, the GIC asked for innovation. It asked for certain kinds of carving in, carving out. She asked whether lowering some of the deductibles and keeping other things the same will accomplish the premium increase we are discussion. She asked if it is basically underwritten?

The Executive Director clarified that she is not asking for new money to do this; the money essentially is coming out of the procurement results. She noted that we have not been able to roll back these common out-of-pocket costs anytime in recent memory. She said that we recommended what we think makes best use of the impact of the initiatives that are still be in play and still yields the results that we aimed for. A result that responds to our market intelligence, is data driven, and based on what we heard, responsive to our members.

She reminded the Commissioners of the benchmarking exercise that looked at the actuarial value of the GIC's plans. Actuarial value compares how rich or poor plans are, and is used in, the health care exchanges, where it is translated into bronze, silver, gold, and platinum. Our plans were 'glatinum.' The GIC plans were not the very highest that are offered in the market, but they were pretty high. She noted that it's an unpopular thing to remind people how rich are plans are, but it's the facts. Despite our members out-of-pocket expenses previously going up, when you actually compare our plans to other markets, other state agencies, and certainly to business, the plans are still very good plans.

The Executive Director said the a $90 copay for specialist is a lot, and while we are not entirely backing off from the idea that there might be a place in our portfolio for having differential copays, $90 is too much money for people. She noted that we also have tried to introduce here a gradient of out-of-pocket expenses for members depending on what kind of product they enroll in. If you choose to enroll in a product with every provider in the network, then your deductible should be a little higher than that for people who choose to enroll in a narrower network product. The concept is to have deliberate consistency where we want consistency and differentiation where we want differentiation. Furthermore, she noted that over time we want to have product differentiation, so for the benefits in those products, there is some kind of gradient that is explainable.

Commissioner Kaplan asked about the logic of voting on the plan design, and then weeks later voting on the rates. She said it doesn't make sense to her, and asked for the rationale behind doing it that way. She said that the Commission is voting on products, but have no idea what that cost will be to the members.

The Executive Director noted that this is the way it's been done for decades. We need something to model the rates with. When you go through the modeling, there are gates you have to go through in order to proceed to the next step. If the Commission were to say it couldn't make a decision until it sees the rates on February 22, then what we would have to do is at least know what assumptions to make for the modeling. She noted that there's not enough time to engage in an iterative back and forth.

Catherine Moore, Acting Fiscal Director, compared it to buying a car. When you go into a car dealership, there all these different option packages that you can choose. Until you have chosen the options, you don't know what the price is. We have to know what we're pricing to tell you what the prices are. We need you to help us narrow that down, so that when we come to you on February 22, we're coming to you with, essentially, a digestible matrix of here are the plans, here are the prices. She noted that the $8 million investment being proposed is not going to be distributed evenly across all the plans because there are some features that impact certain plans, not others. She noted that we're talking less than 1% for a modest set of benefit enhancements for members.

Commissioner Kaplan expressed that she appreciates the work that the staff has done, but feels uncomfortable that she is expected to vote without knowing what the premium costs will be. She would prefer to know the cost of the individual plans, not just the aggregate.

The Executive Director reminded the Commissioners that they had committed to voting on benefits at the end of the last meeting and that she had committed to come back with a scenario where we could meet that less than 2% aggregate increase. She urged the Commissioners to continue through those series of gates in a logical progression even without complete information about the final solution.

Commissioner Choate asked for confirmation that the Commissioners are being asked to vote on benefits predicated on certain expected cost savings from the procurement. Not reductions, but cost savings, primarily through the pharmacy, and some through the ASO. And what the GIC is recommending is that the way we use those cost savings is primarily to keep the premium, at the absolute minimum, under 2%.

The Executive Director confirmed this and said that she thinks that we can even do a little better than that.

Commissioner Thompson asked about the rationale for lowering the network plan deductible.

The Executive Director said that in general, the limited networks exclude some of the most net low value, highest cost providers. So there's an expectation that those products and the cost in them will run lower than in broad network products. What we would like to do, is incent folks to go into them, if it turns out that's something that works for them and their family.

The Executive Director highlighted any place where what staff had proposed is different from what exists today. She explained there are three portfolios of products: non-Medicare, we sometimes call it commercial; Medicare; and Pool 2, which is this special group that we keep referring to of 10,000 members or so, who are elderly government retirees and retired municipal teachers.

Commissioner Edmonds asked for an explanation of the product categories.

The Executive Director explained that a broad network generally means health plans that have all Massachusetts doctors and hospitals in them. The regional plans have a more limited geography, but it is possible that they have all providers in that geography. The limited network plans, whatever geography they're in, have a subset of the doctors and hospitals in that region.

A question was asked about whether the GIC had the figures on how many people are impacted in that change. The Executive Director said we don't know what people are going to choose. So the numbers would be simply the number of people who are currently enrolled in each of the products. It was asked how many reached their out-of-pocket maximum this past year?

The Executive Director responded that it was less than 1%. The Executive Director next outlined the proposed changes, including the Fallon separate deductibles for medical and pharmacy; the out-of-pocket maximum change for UniCare; and the 3rd tier specialist co-pay reduction for all plans. Also, the recommendation to standardize the telehealth visits co-pay except for Harvard Independence and Tufts Navigator where there is at least the potential for only a $10 primary care physician copay. In that event, the most conservative possible interpretation of mental health parity required setting a $10 telehealth copay for behavioral health.

Commissioner Davis asked if these changes are levelling the playing field among all of the carriers and whether that would makes it really easy to move people from one carrier to another, because they're really getting exactly the same thing, but somebody else is paying the bill.

The Executive Director noted that we do not have that many products. We have a lot of carriers with similar products. She said that products that are like each other ought to have similar copays and deductibles. Let members decide which one they want. The GIC staff seeks to have consistency where it made sense, differentiation where it made sense, and to get rid of some inconsistencies that it couldn't make sense of, or easily articulate the rationale for. We wanted as much as we could to make this understandable, explainable and justifiable. We want to be able to explain what we're doing, what the different products are. If there's a difference, there should be a reason. We want people to make their choices and be able to see side by side what the products are that we're offering. That sort of chassis is standard, and they'll be able to decide based on their needs, preferences, brand loyalty, whatever they choose to make decisions with, which carrier is for them.

A brief discussion ensued about how the GIC developed specialist tiering.

Returning to the product portfolio, the Executive Director noted that the GIC broad network products have three tiers for specialists and the limited network products include tier one and tier two only. There are exceptions to that, but conceptually, that's how it works.

Another brief discussion ensued about Pool 2. The GIC is legislatively mandated to manage that group of members separately and they also must be fully insured. It is made up of approximately 10,000 elderly government retirees of retired municipal teachers.. She described how UniCare, the only vendor bidding for Pool 2, will be offering two other products by July. In general, UniCare Basic is a relatively expensive product and these folks are going to be at risk for what we call "rate shock" without alternatives.

The Executive Director next clarified that there are some people in pool two who are not Medicare eligible, and so they are on the commercial side. She said there are 11,000 total Pool 2 members. Of these, approximately 600 Medicare and 300 commercial members will need to migrate to a new plan (the remainder are already on OME). These 300 commercial members and some of the 600 Medicare members could see significant premium increases. We are trying to help them by offering more products and to help them with the transition. She said that we will chip away at some of the challenges for our members and the GIC, and that Pool 2 is on the list of things to try to do differently in the future, if we can. It doesn't serve the members well and it requires a legislative change.

Chair Sullivan summarized that what she had seen presented was plan designs based on the Commission's prior vote that attempted to ensure that the benefits from the procurement were preserved. At this point, some work has been done to harmonize products, for

consistency. The Commission was being asked to authorize these designs or to make some changes.

Commissioner Gentile asked if a yes vote covers the question of pool two?

The Chair noted it would be simpler if the whole slate were approved. If there's dissension, then we would have to parse it out. The Commission needed to vote to proceed to the next step; on the assumption that this is the product portfolio for July 2018 and then staff would be coming back on February 22nd, with the pricing for the portfolio. Then we'd have the product by product with the actual premiums.

Commissioner Davis asked if there any wiggle room once you do provide the pricing, and for whatever reason there is a feeling among the Commissioners that they might see a lack of equity in certain areas, of certain kinds of goals. Is there any wiggle room to negotiate with the carriers.

The Acting Fiscal Director said that to respond to concerns about the pricing relationship between specific products, we request your answers/approval for the benefit designs today.

Our job is really to do the best we can to explain how we ended up where we ended up, and what are the big trends that account for anything that might be surprising or unexplained. Because we will be completely self-insured, we can look at it premiums in the aggregate and what we're rolling forward at the moment assumes nobody moves as that is the only way we can model.

Chair Sullivan said she remained concerned about the process of not being able, in parallel, to look at product design changes along with the pricing. But that Feb. 22nd is the date that the offers from the carriers need to be finalized for the commission vote. She asked if the GIC could tell the commission what the average range is?

The Executive Director said we have the current distribution of members and using all the information available to us about what's happening with medical trends and what we've been seeing about utilization, we can get the average. We need to finalize with the carriers, everything we know about their structure, the overall construct. We've been talking about product design, to get to the next level of detail for pricing, we need to analyze, literally product by product, what happens.

Dr. Jeff Levin-Scherz from Willis Towers Watson explained that you need to know the plan design to figure out what the likely costs will be. Essentially, the commission has the ability to set premiums, as it wishes. It can distribute the costs in various different ways and some ways of determining premiums might actually lead to more people going into plans which have lower provider contracts. At this point, we know what each of the plans is going to charge as its administrative services fee, but we don't know what the cost of care will be. In order to figure out the appropriate premiums, it is necessary to have actuaries try to sort out how to set the

premiums to meet the commission's goal, which might be being sure no one sees higher premium increases that one would expect and that one could prevent.

At the same time, we don't set premiums encouraging people to go to plans where the total cost to the state and to the member together would actually be substantially more, thereby threatening this really pretty incredible effort to end up with an aggregate premium increase that's less than 2%. The commissioners should feel awesome about the fact that the staff is recommending some benefit enhancements while working hard to set premiums as reasonable as can be with very low premium increases in general compared to what the overall market would see. In addition, there are a lot of choices. And so, if people see a premium increase in their plan that they find is not acceptable for the most part, they will be able to find something different.

The Executive Director indicated that the staff needed your direction to proceed and in order to be ready by open enrollment.

Commissioners continued to question the process of setting rates, and its timing, and role the Commissioners and the public hearing should play. Commissioner Anderson pointed out that the process the staff was following is standard in the insurance industry.

Commissioner Kaplan said that she is not from the insurance industry, she is from the labor union and she represents employees. So, as much as she had learned being on the Commission for the last three years, she didn't understand this process. Logically, it didn't make sense. She said if the insurance industry operates that way, where they do not provide rates until we say this is our menu, then that makes sense.

Commissioner Timothy Sullivan then said that if he got this information 30 days ahead of time to discuss with his constituencies, it might be something he would consider. He said he was angry when he got the information, to have an important vote the following morning. He couldn't discuss it with his constituencies. He said the commission needs to review, the rules and procedures that it follows, as well as looking at its policies going forward. He believed that the information he needed to make decisions was not getting to him in a timely manner to get ready for open enrollment. He said he needs every bit and piece of information so that he can truly and honestly represent the people of the MTA. There are 110,000 members standing behind him. He wants to do due diligence by them and believed that over the last three meetings, he has not been able to do so.

Chair Sullivan agreed that the commission has an obligation to look at these issues and to work during the next year or on the timing, the process, and maybe even talk about it in the June and July meetings. She said she would like to commend the staff for the difficult job in tackling the issues that have come up within the last month and in trying to resolve them in a very short period of time given the restrictions that it had to work under, and to bring forth a better plan than we currently have and to be consistent in how we look at this.

The Chair suggested the commission move to accept what was recommended in the discussion, and move forward to the setting the rates. Commissioner Davis then moved to accept the staffs' proposal. The motion was seconded by Commissioner Chote and passed unanimously.

The Director of Operations, spoke about annual enrollment. He presented the yearly request for funding for the health fairs from the trust funds. He shared the health fair schedule and noted that the GIC will be conducting 13 health fairs across the state, similar to what it's done in prior years.

He noted that three health fairs will be in a time frame from 1:00 to 5:00 PM. In the past, most health fairs have been 10:00 to 2:00, 10:00 to 3:00. In addition, the GIC has added a 3:00 to 7:00 PM health fair out in Springfield. He showed an illustration of how the 13 fairs cover the entire state. He shared that the GIC will conduct coordinator training for about 500 GIC coordinators during the last week of March. These are held in five sessions across Massachusetts. These trainings help deliver the messages for the benefit changes, so coordinators can advise and inform their new and active employees.

Chair Sullivan asked if this is about half of the number of coordinators that are available? Is there on coordinator per agency?

The Operations Director replied that it varies based on the size of the agency. Some of the larger agencies have two to three. The GIC has about 1,100 agencies that it deals with but they are predominantly interacting with active employees. (The GIC staff manages the benefits for the retirees.) .

Chair Sullivan asked if he needed anything from our commissioners to get more of the coordinators out.

The Operations Director requested that commissioners use websites to share the health fair schedule with their constituents. The coordinator training is mostly a message that we want to get to people who do the day-to-day GIC processing;, anything commissioners could do on the web or social media platforms to promote the health fair schedule helps the GIC.

The Chief of Staff discussed other additional communications channels including partnering with the Human Resources Division of the Commonwealth, using social media and outreach to other stakeholder groups, particularly the union leadership.

The Operations Director noted that an email field has been added to our enrollment forms. Also, the GIC had sent out about 220,000 benefits statements that had a field asking members to provide an email address.

The Operations Director noted on the last page of the budget contains the specific request for the commission to authorize the money to spend for this year's health fair activities. These activities include, van rental for all of the transportation of the material back and forth, gas,

mileage, the hotel accommodation, and an annual enrollment kick-off luncheon with all of our vendors at the GIC. Additionally, the GIC provides interpretive services, both at the coordinator training and at the health fairs. (Last year the commission spent, $5,537.39 out of a $10,000 budget.). This year the request was for authority to spend up to $13,575 from the trust fund.

Chair Sullivan proposed a motion to amend the budget to $15,000 to add funds for doing something creative to start collecting some of the email addresses. Commissioner Edmunds made the motion. [second was unrecorded] . The motion passed unanimously.

The Chief of Staff, said there was one final agenda item. She noted that this has been a very challenging period for the GIC and that two team members had stepped up and deserved to be recognized for their contributions. She presented "Certificate of Appreciation" awards to Janine Hynds and Nick Vogler.

Chair Sullivan added her thanks to Janine and Nick, as well as the entire staff and the Commissioners as well. She thanked everyone for the time and made a motion to adjourn. The motion was approved unanimously and the meeting adjourned at 5:10 p.m.

Respectfully submitted,

Roberta Herman, M.D.
Executive Director

Appendix A

Materials Distributed at February 6, 2018 Commission Meeting

1. Commission Meeting Package – February 6, 2018